Attachment #2

MENTAL HEALTH AND DISABILITY SERVICES COMMISSION
September 19, 2013, 9:30 am to 3:00 pm
Pleasant Hill Public Library
5151 Maple Drive, Pleasant Hill, IA
MEETING MINUTES

MHDS COMMISSION MEMBERS PRESENT:

Neil Broderick
Richard Crouch
Jill Davisson
Lynn Grobe
Representative Dave Heaton
David Hudson (by phone)
Betty King (by phone)
Sharon Lambert (by phone)
Gary Lippe
Zvia McCormick
Brett McLain
Rebecca Peterson
Deb Schildroth
Patrick Schmitz
Suzanne Watson
Jack Willey

MHDS COMMISSION MEMBERS ABSENT:

Senator Joni Ernst
Senator Jack Hatch
Representative Lisa Heddens
Chris Hoffman
Susan Koch-Seehase
Marilyn Seemann

OTHER ATTENDEES:

Pam Alger	DHS, Targeted Case Management
Theresa Armstrong	MHDS, Bureau Chief Community Services & Planning
Marilyn Austin	Iowa County Social Services
Bob Bacon	U of Iowa Center for Disabilities and Development
Teresa Bomhoff	Iowa Mental Health Planning Council/NAMI
Tom Brown	Advisory Council on Brain Injuries
Wayne Clinton	ISAC Supervisors Affiliate/Story County
Diane Diamond	DHS, Targeted Case Management
Kristi Dierking	Warren County
Marissa Eyanson	Easter Seals Iowa
Connie Fanselow	MHDS, Community Services & Planning
Jim Friberg	Department of Inspections and Appeals
Lynsie Hanssen	Iowa Department of Human Rights
Melissa Havig	Magellan Health Services
Ken Hyndman	Des Moines County
Diane Jackson	Greene, Guthrie, & Audubon County CPC
Julie Jetter	MHDS, Community Services & Planning
John Pollak	Legislative Services Agency
Jim Rixner	Siouxland Mental Health
Joe Sample	Iowa Department on Aging
Renee Schulte	DHS Consultant

Rick Shults	DHS, Administrator MHDS Division
Deb Eckerman Slack	ISAC County Case Management Services
Jennifer Vitko	Wapello County

WELCOME AND CALL TO ORDER

Jack Willey called the Commission business meeting to order at 9:35 a.m., welcomed attendees, and led introductions. No conflicts of interest were identified for today's meeting. Quorum was established with 11 members present and 3 members participating by phone.

APPROVAL OF MINUTES

Richard Crouch made a motion to approve the minutes of the August 15 meeting as presented. Deb Schildroth seconded the motion. The motion passed unanimously, with Betty King, Sharon Lambert, and David Hudson voting by phone.

REGIONAL CORE SERVICES RULES

Theresa Armstrong reviewed the process of developing the core services rules. A committee of Commission members met several times to consult with DHS and provide guidance during the drafting and revision of the rules. In June, the Commission voted to notice the rules for public comment. The public comment period was open through August 15. The committee met again to go over the comments received and offer further guidance in drafting responses to the comments and making final revisions. The rules being presented today include comments and responses, and the changes that were made in response to input received. Today the Department is asking for the Commission's approval to adopt the rules. If approved, the rules will go to the DHS Rules Administrator and then to the Legislative Services Agency for final reviews, and will be presented to the legislative Administrative Rules Review Committee (ARRC) by November.

Renee Schulte reviewed the public comments received and the responses. Comments fell into six general topic areas:

1. General format (2 comments)
2. Definitions (34 comments)
3. Core Service Domains (8 comments)
4. Access Standards (5 comments)
5. Practice Standards (7 comments)
6. Evidence-Based Practices (3 comments)

<u>Comments on General Format</u>:

- Standard rule formatting places definitions first, followed by the rules.
- Cross-references to Iowa Code must be used rather than repeating Code provisions in the rules; Code and rules need to be read together.

Comments on Definitions:

- Some service definitions include a description of who can provide the service because it is an integral part of service definition and is necessary ensure providers are qualified and credentialed for the service.
- The definition of "case management" includes the expectation that services preserve an individual's ability to access services and supports.
- The definition of "case management" is not limited only to targeted case management.
- The definition of "case management" reflects the description of case management in Iowa Code as a service.
- The definition of "crisis evaluation" incorporates activities necessary to evaluate the immediate situation and resources available to address the crisis.
- The definition of "crisis care coordination" allows regions and providers flexibility to determine who should be involved in developing a crisis plan.
- Crisis care coordination is not identified as a core service in Iowa Code; it is a component of the core service of community-based crisis intervention.
- Stating a "preference" of day habilitation services to be delivered in community-based integration settings is not appropriate to rules provisions; integrated settings are supported and flexibility in service delivery models is allowed.
- The term "emergency services" was changed to "emergency care" to match the Iowa Code reference in the definition.
- No additional wording was determined necessary in the definition of "family support service."
- A change was suggested from "family support" to "individualized family support"; no change was made because "family support" is the language consistent with Iowa Code.
- It was suggested that the definition of "family support" needs clarification; no changes were made.
- The definition of "family support specialist" was determined to be adequate without adding that the person would have similar life experiences.
- The definition of "group supported employment" is consistent will definitions currently used.
- The definition of "health home" corresponds to the language of Iowa's Medicaid state plan amendment.
- The definition of "home health aide" is consistent with the definition used by Medicaid; the legislation stated that non-Medicaid services should be parallel to and consistent with Medicaid service provisions when possible.
- The definition of "individual supported employment" as written is consistent with the definitions currently used and allows flexibility in application.
- A definition of "integrated treatment of co-occurring substance abuse and mental health disorders" has been added to be consistent with the definitions for other evidence-based practice standards published by the Substance Abuse and Mental Health Administration (SAMHSA) and included in the rule.

- The definition of "job development" is consistent with definitions currently used and is broad enough to include individual supported employment.
- The definition of "job development" is broad enough to include the process of working with employers to secure employment opportunities for individuals.
- The definition of "medication prescribing" is sufficiently clear to distinguish it from the definition of "medication management."
- The term "mental health inpatient treatment" does not require a definition.
- The Code reference relating to "mental health outpatient therapy" was corrected.
- The definition of "peer support specialist" is intended to reflect the qualification that the individual providing the service has experienced a severe and persistent mental illness.
- The definition of "prevocational services" is consistent with the definitions currently used and is broad enough to encompass career exploration and planning, benefits and financial training, and related activities.
- Delivery of prevocational services in integrated settings is supported, but stating a preference for service delivery models is not appropriate in rules provisions; the language provides flexibility in service delivery models.
- The definition of "reasonable close proximity" is consistent with the provisions in Iowa Code for inpatient psychiatric services; the term is not used as an access standard for other core services.
- The definition of "respite" was changed to replace "brief" with "temporary" and "rest" with "relief."
- The definition of "supported employment" is consistent with the evidence-based practice definition and the scope of the definition is sufficiently broad to include career exploration and planning, benefits and financial training and related activities.
- The definition of "trauma informed care" was corrected by replacing "expressing" with "experiencing" violence.
- No definition was added for "developmental trauma"; the term is consistent with nationally recognized training by the National Center for Trauma Informed Care.
- No definition was added for "brain injury resource facilitation" because it is not a core service identified in Iowa Code.

<u>Comments on Core Service Domains:</u>

- A suggestion was made to add a core service domain for "prevention and wellness"; Iowa Code does not include prevention and wellness as a core service domain and the rules must be consistent with the Code.
- "Core Plus" services, called additional services in Code, will be defined in a later administrative rules package.
- It was suggested that work services and residential care services be added to core services; those services are permitted to be funded under the existing core services domains, but not included in the Iowa Code provisions so cannot be identified as core services.
- It was suggested that many people are accessing non-core services and the rules state that no person will be denied services or placed at risk for arbitrary

funding decisions. Core services must be available in all regions, but not every provider must provide every service, and providers can also offer additional services.

- This rule package is one of several that will form Chapter 25 of the administrative code; the independent appeal process for decisions made under this chapter will be described in the regional service system rules package that is pending.
- Specifics related to reporting will also be included in the regional service system rules package.
- It was suggested that "shall" should replace "may" in the statement that the regional services system may provide funding for other services; the word "may" is consistent with the applicable provision of Iowa Code.
- A sentence was added to clarify that regions must ensure core service domains are available in the region "within funds available" in accordance with Iowa Code Sec. 331.397.
- It was suggested that services be listed by core service domains rather than by individual services; the core service domains in Iowa Code do not require further definition, but core services definitions are needed. Sentence was added to clarify that regions must ensure core service domains are available in the region in accordance with the provisions of Iowa Code Sec. 331.397.
- Language was added to clarify that the transition to new services is expected to include and respect the recommendations of the person and their care team; this is consistent with person-centered services.

Comments on Access Standards:

- The timeline for a supported employment initial evaluations is consistent with the requirements of the Iowa Vocational Rehabilitation Services program.
- It was suggested that regions should not be limited to Medicaid rates for home and vehicle modifications; the Medicaid reimbursement rate is appropriate for providers across the payment spectrum.
- The lifetime limit on home and vehicle modifications is consistent with Medicaid program limits and appropriate to prevent regions from unlimited expense requests.
- Access standards are needed to implement desire system change and serve as an expectation for providers and individuals receiving services; regions have reasonable control over access through their contractual arrangements with providers.
- Iowa Code does requires that each region has the capacity to provide all required core services; it does not requires that regions provide all services within its geographic borders or that it provide all services within each county.
- It was suggested that appropriate services such as brain injury resource facilitation be added to the access standards; it cannot be added because it is not a required service.

Comments on Practice Standards:

- The definition allows regions to identify a generally recognized professional organization for co-occurring training in their service system regional plan. It was

suggested that the Brain Injury Alliance of Iowa be named; regions have the flexibility to identify organizations they will use.
- The word “applicant” was changed to “region” for clarity and consistency.
- It was suggested that language be added to ensure that regions have services available in each core service domain that reflect the principles of Olmstead and community integration; Iowa Code does not specify such a provision and rules must be consistent with the Code.
- It was suggested that provisions should be added specifying that funding and technical assistance should be made available to more redesign forward; funding is addressed in legislation, not in rules.

Comments on Evidence-Based Practices:
- It was suggested it is a duplication of effort for regions to independently verify the fidelity of services that are otherwise accredited. The Department, Magellan, and national accrediting bodies do not measure the fidelity of and evidence-based practice when they accredit providers.
- It was suggested that the Department not prescribe the use of evidence-based practices until similar requirements are followed in State facilities; Iowa Code requires that a region ensure access to providers that demonstrate competencies in evidence-based practices, but does not require all providers to provide specifics EBPs or preclude them from providing other EBPs.
- It was suggested that DHS is eliminating case management for persons with mental illness; these rules define non-Medicaid core services for the MHDS regions.
- The Iowa code requires MHDS regions to implement evidence-based models of case management.
- It was suggested that prescribing the use of specific evidence-based practices limits the use of person-centered and cost effective alternative interventions; Iowa Code requires that a region ensure access to providers that demonstrate competencies in evidence-based practices, but it does not requires all provides to offer EBPs nor does it preclude the region from providing other EBPs.
- It was suggested that the EBP of permanent supportive housing be made available to persons with intellectual and developmental disabilities; no change was made because research supporting the EBP has only been demonstrated for persons with mental illness.
- The definition of “supported employment” is the one used by SAMHSA for the evidence-based practice of supported employment, because evidence-based practices are required according to Iowa Code Sec. 331.397.5.
- The evidence-based practices in this rule package are consistent with a previous rule package, and regions may provide other evidence-based practices as well.
- It was suggested that nationally recognized core principles for providing family support and core indicators of success be added to the practice standards; these rules focus on the current requirements for MHDS regions and additional requirements for the system will be addressed in other rules packages.

- There are no provisions for waivers in this rule package because requests for the waiver of any rule may be submitted under the Department's general rule on exceptions to policy.

Patrick Schmitz commented that he has found working with DHS staff on the rules development process has been a good and productive experience. The Commission has had a considerable amount of input into the process and there have been many more changes than those that are evident in the comment and response section. Jill Davisson commented that she has been very impressed with the expertise and hard work demonstrated by committee members and their concern about how these rules will impact people's lives. Theresa Armstrong expressed her appreciation for the work done by the Commission and how it has helped to improve the rules.

Motion & Vote – Patrick Schmitz made a motion to adopt and file the rules for regional core services as presented. Richard Crouch seconded the motion. The motion passed unanimously. Betty King, Sharon Lambert, and David Hudson participate in the vote by telephone.

Rick Shults thanked the Commission and the members of the committee, saying he really appreciates the thoughtful and deliberative approach they have taken in reviewing the rules, offering input, and carefully considering the comments received from others. He said he is hopeful that the process is proving meaningful to the Commission members and that he is open to suggestions on how to improve it.

PEER SUPPORT UPDATE

Renee Schulte shared a handout entitled "Peer Support Service Side by Side" and presented a short update on work being done to determine what peer support should look like in Iowa. Magellan and DHS have been talking about peer support as a service and peer support as a part of care coordination, including service criteria, provider qualifications, and issues such as utilization and caseloads. The handout compares the definitions, components, provider qualifications, and eligibility criteria for each of the peer support functions on pages 1-3, and makes a similar comparison for Family Peer Support on pages 4 & 5.

Peer Support as a Service – includes education and information, individual advocacy, support groups, crisis, and respite to assist individuals in achieving stability in the community through goals identified in the person's treatment plan.

Peer Support as Care Coordination – includes providing positive reinforcement, education and whole health support to individuals assigned to the integrated health program, and includes education and information, individual advocacy, support groups, crisis, and respite to assist individuals in achieving stability in the community through goals identified in the person's treatment plan.

Renee noted that there are differences between the two in terms of function and caseloads, although provider qualifications would be the same for both. There is interest in raising the bar for qualification to providing the service to ensure that people trained will be fully qualified to be hired to provide the service. The Department has already received some input and is working on some changes to the draft; more input is welcome.

Rick Shults said that one of the goals was to be clear that moving forward peer support staff will be bringing their lived experience as a member of the Integrated Health Home care coordination team. The teams will include a nurse manager, a care coordinator, and a peer support specialist. Rick said that role will not meet everyone's total peer support needs and that is not the full extent of peer support that people should be able to access; Peer Support will also be offered as a service. This is the beginning of the peer support conversation to help everyone get a mental image of the model for the two types of peer support and the expectations that the Department is developing for peer support. The qualifications described in the handout are a future expectation. Certification is available for PSS through the Iowa Board of Certification, but it is not yet required; that would be a new expectation. Certification is not yet available in Iowa for Family Peer Support.

Regions – Theresa Armstrong indicated that the most current map of the MHDS regions is posted on the DHS website. The only county outstanding at this point is Jefferson. Jefferson County has appealed the denial of its application to be exempt from joining into a region. The appeal hearing was held last week and the decision of the Administrative Law Judge (ALJ) is pending; it is expected within 30 days. Carroll County made the decision to join the Rolling Hills region. Warren County has changed regional groups to join Central Iowa Community Services, along with Boone, Franklin, Hamilton, Hardin, Jasper, Madison, Marshall, and Story Counties.

Three of the regional groups have submitted 28E agreements to the Secretary of State. The agreements will also have to be approved by the Department because the legislation makes some requirements for regional agreements that are over and above the general requirements for all 28E agreements. ISAC and DHS worked together to made a template that is now available for groups to use. The agreements have to be in place by June 30, 2014. All the regions have done what was required for the letters of intent and all letters of intent have been accepted by the Department, which means they have accomplished what needed to be done by December 31, 2013.

Children's Services Workgroup – Meetings dates have been set for the Children's Services Workgroup. The group will meet on October 1, October 15, October 29, and November 12. All meetings will be held at the Polk County River Place Building on Euclid from 10:00 a.m. to 3:00 p.m. The Legislature asked the workgroup to start meeting again and continue working on the development of the children's MHDS services system. Last year they looked at addressing out of state placements and developing statewide systems of care. This year they will look at some of the best practices from other states and try to take the next steps in building a collaborative

system. The legislature also charged them with looking at the number of councils, boards, and committees that deal with children's issue and making recommendations for combining or consolidating some of the functions. Kevin Martone from the Technical Assistance Collaborative (TAC) will be facilitating the group. Their report is due to the legislature on November 15.

Legislative Interim Committee – John Pollack shared that the committee will meet in Des Moines on October 22 from 9:30 a.m. to 4:00 p.m. to review the status of redesign implementation. They have a second meeting scheduled for December 17 to discuss financial issues, including the adequacy of the $47.28 per capital funding rate. The co-chairs are Representative Dave Heaton and Senator Joe Bolkcom. The membership is the same as last year with two exceptions – Representative Cindy Winckler has replaced Representative Mark Smith, and Senator Robert Hogg has replaced Senator Jack Hatch.

Equalization Payments – $29.8 million was appropriated for equalization payments. Fifty-four counties were eligible. Counties with unpaid state bills had to pay them or reach an agreement with DHS for a payment plan. The first 12 counties were paid on July 11. Seventeen more counties have now been paid. Nine counties are in the negotiation process for a payment plan. Two counties have committed all their equalization dollars to offset their state bills and will be paying the remainder of what they owe. Fourteen counties are still making plans. Ten of the fourteen are within the County Social Services (CSS) region and they have chosen to receive their payment as a region.

Abbe Center RCF Closing – The Abbe Center is closing its Residential Care Facility (RCF) and RCF/PMI in Linn County at the end of this month as a result of a decision made by Abbe's Board of Directors. There were 75 people living them who needed to move to other settings. As of yesterday, 17 residents were left. There have been regular phone calls with Abbe, DHS, and Magellan to keep updated on the progress.

Representative Dave Heaton asked if the closure was due to the Medicaid funding limitation for IMDs (Institutions for Mental Disease) that are larger than 16 beds and if there was a deadline. Rick responded that this was an individual facility decision by the Abbe Board and there is no firm deadline set by anyone else. He said the Department wants to work in a collaborative way to help any facilities that are closing or downsizing to develop a reasonable transition process that will support the residents who need to move elsewhere. He also said that Iowa does not want to be in the position of having forced closures like some other states have experienced.

Release of Request for Proposal for SIS Assessments – MHDS legislation requires core standardized assessments for people with mental illness, intellectual disabilities, and brain injuries. Iowa is also a Balancing Incentives Payment Program (BIPP) state and that requires core standardized assessments across all of the long-term care populations. The Supports Intensity Scale (SIS) was designed for people with intellectual disabilities (ID) and developmental disabilities (DD). Bidders on the RFP will

be asked to help determine the other assessments that should be used. Assessments will be needed for a variety of population groups, including those served by the HCBS Waivers such as Elderly, AIDS/HIV, and Physical Disability. The work that has already been done by the workgroups will not be lost. Proposals are due November 16 and it is anticipated that work will begin in January. The SIS will be implemented beginning in April.

SAMHSA Site Visit – Iowa will have a site visit by representatives of the Substance Abuse and Mental Health Services Administration (SAMHSA) to review spending and use of the Community Mental Health Service Block Grant next week, on September 24, 25, and 26. The federal Block Grant, administered by SAMHSA, provides about $3 million in funding to Iowa each year. The last site visit was four years ago. Each state was asked to choose a topic; Iowa chose to focus on the collaborate work between the mental health authority and the Medicaid authority, including Medicaid expansion, Integrated Health Homes, and the Balancing Incentives Payment Program.

Reviewers have expressed specific interest in the MHDS redesign in Iowa and the new Iowa Health and Wellness Plan. They will meet with state staff, Mental Health Planning and Advisory Council members, and a small group of individuals and families receiving services. There will be meetings with program staff and financial staff so they can get a picture of how the money was spent, how we contract for services, how contracts are monitored, what services are provided, what evidence-based practices are used, and what kinds of outcomes and data we have produced. During previous visits, they have also met with providers but because they are limited on time in each state, they will not this year. If there are providers who have input to share, they can talk to Teresa Bomhoff, who will be meeting with them as the Chair of the MHPC.

Iowa Health and Wellness Plan – The state needs and wants help in getting the word out to people about the new Iowa Health and Wellness Plan. It will be important to find different and innovative ways to assist people in enrolling and gaining access to the benefits they are eligible to receive.

There is one important concept for people with serious mental illness, chronic illness, chronic substance abuse, or other more complex health issues to understand. Individuals who meet a defined threshold of care or treatment needs will be considered “medically frail.” This is a federally designated term, which essentially, means that certain individuals that fall into a special eligibility category that allows them to be enrolled by default into the regular Medicaid program. That program can provide the higher level of comprehensive services they need. They will be eligible for coverage based on the new coverage groups, but can receive the full benefits available under the Medicaid program. Individuals identified as “medically frail” can choose to stay in the Wellness Plan or the Marketplace Plan, but they will receive better coverage under the Medicaid Plan. Everyone should have the best coverage to meet their needs, but they also have choice. More work will be done to recognize and develop opportunities to identify people who would fall into this category.

State Innovation Model (SIM) – Rick Shults shared a handout entitled "Iowa's SIM Grant Summary," saying that the SIM grant is a good example of the strong collaboration between MHDS and Iowa Medicaid. One of the steps was to put together workgroups to look at how Accountable Care Organizations (ACOs) can develop in Iowa. ACOs are one strategy identified in the Affordable Care Act to ensure that healthcare is appropriately coordinated. The SIM Grant, from CMS (Centers for Medicare and Medicaid), is to help the state coordinate with public and private insurers and look at how ACOs can operate in Iowa and what approaches and models need to be developed.

Over the next three years, Iowa's goal is to reduce the growth rate of health care costs while improving care quality by:

- Developing incentives to shift provider focus from the number of patient procedures to achieving positive patient outcomes
- Aligning payment methods with quality strategies
- Implementing integrated care models to improve care coordination and focus on patient well-being
- Improving patient care by ensuring an adequate health care workforce to meet the needs of Iowans

Iowa is using three strategies to meet these goals:

- Adopting the multi-payer Accountable Care Organization model
- Incorporating long term care services and supports and behavioral health into the ACO model
- Promoting good health and well-being, increasing the use of preventative care and decreasing the use of inappropriate emergency services

The Long Term Care group is also looking at disability services. Rick chaired the Behavioral Health group, which had four meetings to talk through the issues and put together a list of recommendations. Workgroup recommendations have been developed related to supporting behavioral health care for persons who need mental health and substance abuse treatment. Their report is not yet completed. Some of the group's recommendations include:

- ACOs must be required to provide the same kind of care coordination provided though the Integrated Health Home model, particularly for people with mental illness or substance use disorders
- This would extend the thinking of ACOs to addressing the needs of the whole person and insure that physical and behavioral health needs are closely coordinated
- People should be able to get that coordination in the place that is most comfortable for them; the place that is a natural fit
- Care should insure that the person achieves recovery and lives a safe, healthy, successful life in their home and community
- People should have access to safe, affordable housing
- People should have access to integrated employment

- People should have access to positive interpersonal relationships
- People should have access to peer and family support
- Intensive community behavioral health support services should be available
- Evidence Based Practices should be available
- There should be access to medication monitoring
- There should be support for primary care physicians
- There should be avenues for information exchange
- Outcomes other than traditional health care outcomes are important
- The value and contribution of the existing system should be recognized
- Transition time will be needed

The workgroup's recommendations will go the steering committee for the SIM grant.

Suzanne Watson asked Rick if he could provide any information that would address the unknowns about the future of case management for people with intellectual disabilities. She said the uncertainties surrounding employment for case managers are very difficult for everyone involved. Rick acknowledged that the unknowns are very difficult, but noted that the group did not really talk about specific models. The IHH model is designed around the needs of people with mental illness and a model for the ID population has not yet been identified.

Ricks said that the IHHs offer coordination between intensive behavioral health services and physical health care and should be looking at housing, employment, and relationships. The ACOs include IHHs in an overall scheme along with medical clinics, hospitals, and dental services. The principles of the IHH need to be within the umbrella of the ACO and the IHH is one critical component of the ACO. IHHs become very valuable to the ACO because the ACO does not have the relationships that the IHH can build and bring into the overall picture. Rick said ACOs and IHHs were both called for in the Affordable Care Act, but the law did not address how they would work together so there are still many unanswered questions, but the conversation is going on.

Jill Davisson said she is also concerned about the uncertainty among frontline workers who are unsure about where their future will be. Rick Shults responded that there are some answers with regard to behavioral health services, and there is fear that ID case managers will be affected similarly, but that is just not clear yet. Representative Heaton commented that it will be important to keep the qualified people that will be needed as we move into the new system.

Deb Schildroth asked if there has been discussion regarding the number of ACOs or IHHs that will be needed or allowed. Rick responded that no firm numbers have been established for IHHs. Any entity that wants to serve as an IHH has to have the capacity to do so and each one needs to serve enough individuals to be financially viable, which is a discussion that is happening at Magellan. The ACO approach is going to be more regional, and more population based. It is not as difficult to have an economy of scale with the IHH approach and make it work. Rick said some conceptual models for ACOs

have been introduced in the SIM workgroup, but that is about as far as the discussion has gone.

Richard Crouch asked if there is a definite timeline for developing the ACOs. Rick responded that it is a part of the transition to the Iowa Health and Wellness Plan and there is not a strict timeline. Patrick Schmitz commented that Accountable Care Organizations have been around for years and when the Affordable Care Act was passed that was recognized as the direction that things are going. There has not seemed to be a willingness to discuss that as a part of regionalization. It is going to be a complex system and both Medicaid and non-Medicaid services are likely to be impacted by the changes. There are still many unanswered questions about what all that is going to look like, yet deadlines are fast approaching.

PUBLIC COMMENT

Jim Rixner commented that he runs an integrated Health home program in Sioux City and has seen positive consequences. He said he hired all but one of the former case managers to become care coordinators and the care coordination model is working really well. Jim said that he has been trying to recruit a psychiatrist for 15 years and in the last two days has found two who are interested because St. Luke's Hospital wants to be the Accountable Care Organization and is providing the money to hire the psychiatrists that are needed. He said this model brings the financial resources of hospitals in to help provide what community mental health centers cannot do on their own. He said the county has told him that nearly all the applications they are receiving that would have been eligible for county funding are now going to be eligible for the Iowa Health and Wellness Plan and only a handful will actually need county funding going forward.

Joe Sample commented that there are two more listening sessions scheduled for people who want to learn more about the State Innovation Model and the Iowa Health and Wellness Plan. There will be one in Waterloo in Friday and one in Cedar Rapids the following Friday.

Teresa Bomhoff commented that individuals or groups may submit public comment on Iowa's healthcare plans until September 26. Information on submitting comments can be found on the website. She noted that it is wonderful to see that Iowa is envisioning how we are going to take care of people with behavioral health concerns whose income is up to 138% of FPL, but there are many people with incomes above that level who will not have access to the same continuum of care. She said she would like to the same array of services available to everyone, no matter who the payer is, which would mean equitable services for behavioral health, not just parity in removing limits. Teresa said that if we are going to have a mental health system that will build the capacity to support PACT and crisis response teams all over the state, all payers need to help support it.

A lunch break was taken at 12:00 p.m.

The meeting resumed at 1:00 p.m.

Integrated Health Homes – Jim Rixner, director of Siouxland Mental Health in Sioux City, talked about his experiences recent with integrated health homes. Jim said that as a member of the Iowa Mental Health Planning and Advisory Council, he has listened to many discussions over the last year and understands the anxiety that exists at the county level with regard to the transition of case management. Jim said he works with one of the four programs in Iowa that began integrated health homes as pilot programs. The Siouxland CMHC created a small exam room in the community mental health center for health care exams to be conducted on site. He said that it is well known that people with serious mental illness often do not live long because of physical health conditions that are secondary to their mental illness. Since the IHH program has been implemented, people are keeping their appointments and the CMHC is seeing less cancellations and no-shows; people are getting better health care and it also results in better financial viability for the mental health center.

Jim said that the University of Iowa psychiatrist he recruited over the weekend is a very accomplished physician who speaks about five languages and likes what she sees in the IHH program. She has expressed interest in becoming dually certified as a primary care physicians and a psychiatrist. Jim said that the CMHC works on a zero margin, month to month, and it would have cost about $100,000 just to recruit two new psychiatrists. Hospital systems have funds to pay the recruitment costs and salary, and their investment is critical to the process because it allows the CMHC to pay only its portion of the salary match. He said he believes hospitals want to be able part of the solution under the coming of affordable health care. IHHs can also provide better coordination to control medication shopping and provide medication availability when a person leaves the hospital.

IHH teams can potentially serve ten times the number of people that were served under traditional Targeted Care Management. Those who were receiving TCM are identified for Intense Care Coordination, which is the one-on-one level of support that they need. Experienced TCMs could transition into taking on that type of care coordination, which would allow people to stay with the same case managers/care coordinators they had been working with in the past. Each IHH team includes a nurse manager, a care coordinator, and a peer support specialist. Peer support is a vital component of the IHH team. Jim said he has worked with amazing peer support specialists who can talk about what they have learned through experience and provide support for others who are in crisis or working toward recovery. Jim noted that there is still work being done to find all the people who could be identified as eligible for IHH services.

The program has been very successful for the people who have been using it, and it provides more flexibility that Targeted Case Management. Care coordinators will have a mix of intensive care coordination clients and regular care coordination clients, who will require a lesser level of support. Jim said there are incentives to meet outcomes and that the IHH model has changed the way they work for the better. He said that the opportunity to engage with the major hospitals in the State, including the University of

Iowa, is exciting and he sees a good public-private partnership beginning for form because of the move to an integrated health home model.

Rick Shults said that the Department is trying to do two things in sharing this information: change how we talk about IHH care coordination, and be clear about the role of peer support. Related to care coordination, there is the issue of individuals who need intensive care coordination. Rick said there have been many conversations about caseload, and the bottom line is that the frequency of contact needed is a more meaningful piece of information than the number of individuals on a coordinator's caseload. People who need to be contacted frequently will receive intensive care coordination, and it makes more sense to talk about the frequency of contact each person needs in determining how many people a coordinator can reasonably support. Rick said that work is being done to make sure that there is data to show that the resources needed to achieve this are available.

With respect to the peer support piece, there has been a perception that peer support specialists working in IHHs had to be full time employees, but that is not the case. People have expressed concern about the overall wellness and well-being of peer support specialists if they are expected to work full time because they are people with lived experience who are in recovery and need the flexibility to manage their own health. Rick said he wants to get the message out that peer support specialists do not have to work full time and will have that flexibility. There will be more specifics in the future.

The people who are currently receiving services are easily found to enroll in the IHH program, but there are challenges in locating all the new people who could benefit from being part of an IHH.

Magellan will take the lead in developing the integrated health homes. Melissa Havig noted that some providers are reaching out to Magellan because they have an interest and she said that Magellan is taking steps to talk to community mental health centers and other high volume providers. The IHHs will be introduced in phases. We are now in the first phase, the second phase starts in April of 2014, and the final phase that will make the program statewide, starts in July of 2014.

Neil Broderick offered an update on the children's IHH program at Orchard Place. At about 90 days into the process, they have hired a program director and 35 new staff people. Neil said they started with a list of 2700 children that they were supposed to have served, but have found about 500 children on the list that had not been previously served by Orchard Place. He said they have been working to contact everyone on the list, but the information available is sometimes not up to date and it has been a bigger job than they expected.

So far, they have enrolled about 800 children and are conducting outreach to educate people that the service exists and they are ready and willing to provide it to eligible children that can be identified. For the first 90 days of the program, they were

compensated for the entire list, and thereafter providers were only to be compensated for those who they enroll. Due to the difficultly in contacting many of the families on the list, they have been given another 30 days of compensation to work on the enrollment process. Neil said that with this model, they are able to offer support to parents as well as the child, and they have been very encouraged by the great feedback they have received from the families they have started to serve. Schools, hospitals, and juvenile courts have been positive about the coordination efforts as well. He said it has been discouraging to spend so much time trying to find the children and families that need the support, but once the connection has been made, everything else has been very encouraging. Gary Lipped said he has been hearing the same thing from the other sites. The key issue is finding people because they are very mobile and often the data from IME does not include a current address.

REGIONAL RULES COMMITTEE

The Regional Rules Committee met last night. Suzanne Watson, Jill Davisson, Rebecca Peterson, Deb Schildroth, Patrick Schmitz, and Jack Willey participated, along with Renee Schulte, Theresa Armstrong, Julie Jetter, and Connie Fanselow from MHDS. The committee reviewed each of the comments and made recommendations on changes to the rules document. Patrick Schmitz said that some of the comments had been based on the copy of the rules that was distributed at the last Commission meeting and since some clean-up had been done by the Legislative Services Agency before the rules were published, some of the suggested changes had already been made before public notice. Patrick noted that the committee considered the substance of each comment without knowing who submitted the comment, so they would not be influenced in any way by the source of the comment.

More specific guidelines were requested in several areas, but it was determined that it was important that regions have some flexibility in deciding how they want to do things and what works best for them in terms of some aspects of service delivery and regional finances. The group felt it was important to leave room for creative ideas. Other comments wanted less specificity, so there was an attempt to find a good balance between placing limits and allowing individual variation.

In considering all the comments, DHS is obligated to follow what is in the legislation. Agencies can only do by rule what they are authorized to do by the Code. Efforts were made to tie the rules back to the language in the Code, but not to repeat it. Many rules also tie back to the definitions. Some of the comments did not pertain directly to this section of the rules, but to how it relatives to core services, outcomes, and other pieces that are or will be contained in other rules packets.

Next steps – DHS will take the input provided by the committee members last night and write up the comments and responses to be added to the rules document. Some changes will be made and then the rules will go to the Rule Administrator for review and preparation. The rules package will then come back to the full Commission next month and the Commission will be asked to vote to adopt the package just as the Core

Services rules package was adopted today. If any significant changes are made, that will be communicated to the Committee prior to the October meeting.

NEXT MEETING

The next MHDS Commission meeting is scheduled for October 17, 2013 at ChildServe in Johnston. It will be a joint meeting with the members of the Iowa Mental Health Planning and Advisory Council.

PUBLIC COMMENT

No additional public comment was offered.

The meeting was adjourned at 2:00 p.m.

Minutes respectfully submitted by Connie B. Fanselow.